CHAPTER

9

DENIAL, REDUCTION, SUSPENSION OR TERMINATION OF WAIVER SERVICES

Any time a waiver service is denied, reduced, suspended, or terminated, the consumer and/or legal guardian must be given written notice to include the details regarding the denial, reduction, suspension, or termination of service(s), allowance for appeal/reconsideration, and a ten (10) calendar day waiting period before proceeding with the reduction, suspension, or termination (when applicable).

It is a Federal requirement for the State to provide an opportunity for a fair hearing. According to Medicaid policy, the State (in this case, the DSN Board/Provider) must send written notice at least ten (10) calendar days before the date of action. The following reasons do not require a ten (10) calendar day notice before proceeding with the action:

- Denial of Waiver service,
- Client requested reduction,
- Loss of Medicaid eligibility,
- Voluntary withdrawal,
- Death,
- Consumer moves out of state, or
- Consumer is admitted to an ICF/MR/Nursing Facility or Jail

If the consumer or his/her legal guardian requests a hearing before the date of action, the State may not terminate, suspend or reduce services until a decision is rendered after the hearing. If the State's action is sustained by the hearing decision, the State may institute recovery procedures against the individual or his/her legal guardian to recoup the cost of any services furnished to the consumer, to the extent they were furnished solely by reason of the appeal/reconsideration.

Denials

If the consumer and/or legal guardian requests a service(s) that is denied (either at the local or state level), the Service Coordinator or Early Interventionist is responsible for completing the **Notice of Denial (MR/RD Form 16-A)** within two (2) working days of notification that the service request is denied. The service or services that were denied should be indicated on the form along with the reason and comments to support that reason. If the service is currently being authorized through the MR/RD Waiver and the request was for additional units, the services will continue as authorized prior to the request. This should be explained to the consumer and/or legal guardian in the comments. The original **Notice of Denial (MR/RD Form 16-A)** is sent to the consumer

and/or legal guardian along with the appeals process included on the back or attached. A copy should be placed in the consumer's file.

Terminations

If a consumer's service(s) are scheduled to be terminated, the Service Coordinator or Early Interventionist is responsible for completing the **Notice of Termination of Service (MR/RD Form 16-B)** unless the planned termination was requested by the consumer/legal guardian. The service(s) that are scheduled to be terminated should be indicated on the form along with the reason and comments to support that reason. The effective date for termination will be ten (10) calendar days from the date that the form is completed, which allows the consumer ten (10) calendar days notice prior to termination of the service and the opportunity to appeal that decision prior to termination (previous exceptions noted apply). If the consumer appeals the decision within 10 calendar days of the notification, then the consumer may choose to have the services uninterrupted while awaiting the outcome of the appeal. However, if the appeal is upheld, then the consumer will be liable for payment of those services. Nevertheless, the consumer has a total of thirty (30) calendar days to appeal the decision; however, the service will be terminated if the service was not appealed within ten (10) calendar days. The original **Notice of Termination of Service (MR/RD Form 16-B)** is sent to the provider of the service. The consumer and/or legal guardian will receive a copy along with the appeals process included on the back or attached, unless the consumer and/or legal guardian requested the planned termination. A copy should be placed in the consumer's file.

Please note: If the consumer appeals within 10 calendar days, you must contact the provider of service and ensure that the service is uninterrupted.

Suspensions

During a consumer's enrollment in the MR/RD Waiver, there may be circumstances when service(s) may need to be suspended, but not terminated. One such example would be when a consumer enters the hospital or nursing home. In these instances, all waiver services will be suspended. Many consumers and providers of residential habilitation have made arrangements to have their local provider deliver prescribed drugs and Assistive Technology supplies directly to the residence on a regular schedule. This activity must cease when the consumer is in the hospital or a nursing facility.

If a consumer's service(s) are scheduled to be suspended, the Service Coordinator or Early Interventionist is responsible for completing the **Notice of Suspension of Service (MR/RD Form 16-C)**. The service(s) that are scheduled to be suspended should be indicated on the form along with the reason and comments to support that reason. The effective date for suspension will be ten (10) calendar days from the date that the form is completed, which allows the consumer ten (10) calendar days notice prior to suspension of the service and the opportunity to appeal that decision prior to suspension. **If the consumer has entered in the hospital or nursing home, then ten (10) calendar day notice is not required.** If the consumer appeals the decision within 10 calendar days of the notification, then the consumer may choose to have the services uninterrupted while awaiting the outcome of the appeal. However, if the appeal is upheld, then the consumer will be liable for payment of those services. Nevertheless, the consumer has a total of thirty (30) calendar days to appeal the decision; however, the service will be suspended if the service was not appealed with in ten (10) calendar days. The original **Notice of Suspension of Service (MR/RD Form 16-C)** is sent to the provider of the service. The consumer and/or legal guardian will receive a copy along with the appeals process included on the back or attached. A copy should be placed in the consumer's file.

Once the consumer is ready to resume the service(s), the Service Coordinator/Early Interventionist is required to submit a new authorization form to the designated provider(s).

If the level of care/plan exceeds three hundred and sixty five days (365 days) waiver services must be suspended until the level of care or plan is completed.

Please note: If the consumer appeals within 10 days, you must contact the provider of service and ensure that the service is not suspended.

Reductions

If a consumer's service(s) are scheduled to be reduced, the Service Coordinator or Early Interventionist is responsible for completing the **Notice of Reduction of Service (MR/RD Form 16-D)** unless the planned reduction was requested by the consumer/legal guardian. The service(s) that are scheduled to be reduced should be indicated on the form along with the reason and comments to support that reason. The effective date for termination will be ten (10) calendar days from the date that the form is completed, which allows the consumer ten (10) calendar days notice prior to reduction of the service and the opportunity to appeal that decision prior to reduction (previous exceptions noted apply). If the consumer appeals the decision within 10 days of the notification, then the consumer may choose to have the services uninterrupted while awaiting the outcome of the appeal. However, if the appeal is upheld, then the consumer will be liable for payment of those services. Nevertheless, the consumer has a total of thirty (30) calendar days to appeal the decision; however, the service will be terminated if the service was not appealed with in ten (10) calendar days. The original **Notice of Reduction of Service (MR/RD Form 16-D)** is sent to the provider of the service. The consumer and/or legal guardian will receive a copy along with the appeals process included on the back or attached, unless the consumer and/or legal guardian requested the planned termination.. A copy should be placed in the consumer's file.

Since there has been a change in the provision of the service, the Service Coordinator/Early Interventionist is required to submit a new authorization form to the designated provider(s) with the reduction in service units authorized.

Please note: If the consumer appeals within 10 calendar days, you must contact the provider of service and ensure that the service is not reduced.

If a request for appeal/reconsideration is received by SCDDSN Central Office, the Service Coordinator/Early Interventionist will be notified immediately and receive instructions on how to proceed with the case.

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

MR/RD WAIVER

NOTICE OF DENIAL OF SERVICE

DATE:_____

TO:_____(Please check one): ☐ Consumer ☐ Legal Guardian

ADDRESS:_____

_____

RECIPIENT:_____

YOU ARE HEREBY NOTIFIED THAT THE REQUEST FOR THE FOLLOWING SERVICE(S) FOR THE PERSON NAMED ABOVE HAS BEEN DENIED. YOUR RIGHT TO APPEAL IS ATTACHED.

☐ Respite Care
☐ Adult Day Health Care
☐ Assistive Technology:_____
☐ Personal Care Services
☐ Medicaid Waiver Nursing Services
☐ Habilitation *(specify)*
- ☐ Residential habilitation
- ☐ Career Preparation
- ☐ Day Activity
- ☐ Employment services
- ☐ Community Services
- ☐ Support Center Services

☐ Adult Dental Services
☐ Environmental Modifications
☐ Adult Day Health Care Transportation

☐ Adult day Health Care- Nursing
☐ Adult Attendant Care
☐ Audiological Services
☐ Psychological Services
☐ Behavior Support Services
☐ Physical Therapy Services
☐ Occupational Therapy
☐ Speech-Language Services
☐ Adult Vision Services
☐ Prescribed Drugs
☐ Adult Companion Services
☐ Private Vehicle Modifications

Reason:

☐ Need(s) is/are not justified
☐ Service(s) is available through the state plan
☐ Exceeds service limits
☐ Other_____

Comments(required for all reasons):_____

_____

Service Coordinator/Early Interventionist:_____
DSN Board/Provider:_____ Phone:_____

Address: _____

Signature: _____ Date: _____/_____/_____

Original: Consumer/Legal Guardian Copy: File

APPEALS PROCESS IS ATTACHED

SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Mental Retardation/Related Disabilities (MR/RD) Waiver, Pervasive Developmental Disorder (PDD) waiver, Community Supports (CSW) Waiver and the Head and Spinal Cord Injury (HASCI) Waiver. A request for reconsideration of an adverse decision **must be** sent in writing to the State Director at SCDDSN, P. O. Box 4706, Columbia, SC 29240. The SCDDSN reconsideration process **must be** completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the consumer, representative, or person assisting the consumer in filing the request. If necessary, staff will assist the consumer in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the consumer/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the consumer/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the consumer/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the consumer/representative fully completes the above reconsideration process and is dissatisfied with the results, the consumer/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The consumer/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision.

Division of Appeals and Hearings
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The consumer/representative must attach copy of the written reconsideration notifications received from the SCDDSN regarding the specific matter on appeal. In the appeal request the consumer/representative must clearly state with specificity, which issue(s) the consumer/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30^{th}) calendar day following receipt of the SCDDSN written reconsideration decision. The consumer/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER-NOTICE OF TERMINATION OF SERVICE

DATE FORM IS COMPLETED:_____

PROVIDER: _____

_____

RE: _____ _____/_____/_____
Recipient's Name Date of Birth

Medicaid #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7 8 9 10

YOU ARE HEREBY NOTIFIED TO TERMINATE THE PROVISION OF THE FOLLOWING SERVICE TO THE PERSON NAMED ABOVE. ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE OF _____/_____/_____MAY BE BILLED.

For SC/EI: the effective date is 10 calendar days from the date the form is completed with the exception of death, loss of Medicaid, or admission to an ICF/MR or NF. This allows the consumer 10 days notice prior to termination of service.

- ☐ Respite Care
- ☐ Adult Day Health Care
- ☐ Assistive Technology:_____
- ☐ Personal Care Services
- ☐ Medicaid Waiver Nursing Services
- ☐ Habilitation *(specify)*
  - ☐ Residential habilitation
  - ☐ Day Activity
  - ☐ Career Preparation
  - ☐ Employment services
  - ☐ Community Services
  - ☐ Support Center Services
- ☐ Adult Dental Services
- ☐ Adult Attendant Care
- ☐ Adult Day Health Care-Nursing
- ☐ Environmental Modifications
- ☐ Adult Day Health Care Transportation_
- ☐ Audiological Services
- ☐ Psychological Services
- ☐ Behavior Support Services
- ☐ Physical Therapy Services
- ☐ Occupational Therapy
- ☐ Speech-Language Services
- ☐ Adult Vision Services
- ☐ Prescribed Drugs
- ☐ Adult Companion Services
- ☐ Private Vehicle Modifications

Reason:

- ☐ Change in need no longer justifies original request
- ☐ Change in/no longer meets ICF/MR Level of Care
- ☐ Change in provider availability
- ☐ Entered an ICF/MR
- ☐ Voluntary withdrawal
- ☐ Death (do not send a copy to the family)
- ☐ Medical condition has improved
- ☐ Consumer/legal guardian requested
- ☐ Medicaid ineligible
- ☐ Consumer moved out of state
- ☐ Hospital/Nursing home stay exceeded more than 30 consecutive calendar days

Comments (required for all reasons):_____

Service Coordinator/Early Interventionist:_____

DSN Board/Provider:_____ Phone:_____

Address: _____

Signature: _____ Date: _____/_____/_____

Original: Provider Copy: Consumer/Legal Guardian and File

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SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER-NOTICE OF SUSPENSION OF SERVICE

DATE FORM IS COMPLETED:_____

PROVIDER: _____

_____

RE: _____ _____/_____/_____
Recipient's Name Date of Birth

Medicaid #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7 8 9 10

YOU ARE HEREBY NOTIFIED TO TERMINATE THE PROVISION OF THE FOLLOWING SERVICE TO THE PERSON NAMED ABOVE. ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE OF _____/_____/_____MAY BE BILLED.

For SC/EI: the effective date is 10 calendar days from the date the form is completed with the exception of loss of Medicaid, or admission to an ICF/MR, hospital or NF. This allows the consumer 10 days notice prior to suspension of the service.

- ☐ Respite Care
- ☐ Adult Day Health Care
- ☐ Assistive Technology:_____
- ☐ Personal Care Services
- ☐ Medicaid Waiver Nursing Services
- ☐ Habilitation *(specify)*
  - ☐ Residential habilitation
  - ☐ Day Services
  - ☐ Career Preparation
  - ☐ Employment services
  - ☐ Community Services
  - ☐ Support Center Services
- ☐ Adult Dental Services
- ☐ Adult Attendant Care
- ☐ Adult Day Health Care- Nursing
- ☐ Environmental Modifications
- ☐ Adult Day Health Care Transportation_
- ☐ Audiological Services
- ☐ Psychological Services
- ☐ Behavior Support Services
- ☐ Physical Therapy Services
- ☐ Occupational Therapy
- ☐ Speech-Language Services
- ☐ Adult Vision Services
- ☐ Prescribed Drugs
- ☐ Adult Companion Services
- ☐ Private Vehicle Modifications

Reason:

- ☐ Medical condition has improved
- ☐ Change in provider availability
- ☐ Entered hospital/rehab(less than 30 calendar days)
- ☐ Entered nursing facility (less than 30 calendar days)
- ☐ Change in ICF/MR Level of Care
- ☐ Other_____

Comments(required for all reasons):_____

Service Coordinator/Early Interventionist:_____

DSN Board/Provider:_____ Phone:_____

Address:_____

Signature: _____ Date: _____/_____/_____

Original: Provider Copy: Consumer/Legal Guardian and File

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SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER-NOTICE OF REDUCTION OF SERVICE

DATE FORM IS COMPLETED:_____

PROVIDER: _____

_____

RE: _____ _____/_____/_____
Recipient's Name Date of Birth

Medicaid #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7 8 9 10

YOU ARE HEREBY NOTIFIED TO TERMINATE THE PROVISION OF THE FOLLOWING SERVICE TO THE PERSON NAMED ABOVE. ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE OF _____/_____/_____MAY BE BILLED.

For SC/EI Only: the effective date is 10 calendar days from the date the form is completed which allows the consumer 10 days notice prior to reduction of service); note exceptions in Waiver Manual.

- ☐ Respite Care
- ☐ Adult Day Health Care
- ☐ Assistive Technology:_____
- ☐ Personal Care Services
- ☐ Medicaid Waiver Nursing Services
- ☐ Habilitation *(specify)*
  - ☐ Residential habilitation
  - ☐ Day Activity
  - ☐ Career Preparation
  - ☐ Employment services
  - ☐ Community Services
  - ☐ Support Center Services
- ☐ Prescribed Drugs
- ☐ Adult Dental Services
- ☐ Adult Day Health Care- Nursing
- ☐ Adult Attendant Care
- ☐ Adult Day Health Care Transportation_
- ☐ Audiological Services
- ☐ Psychological Services
- ☐ Behavior Support Services
- ☐ Physical Therapy Services
- ☐ Occupational Therapy
- ☐ Speech-Language Services
- ☐ Adult Vision Services
- ☐ Adult Companion Services

Reason:

- ☐ Change in need no longer justifies original request
- ☐ Change in ICF/MR Level of Care
- ☐ Other_____
- ☐ Medical condition has improved
- ☐ Consumer/legal guardian requested

Comments(required for all reasons):_____

Service Coordinator/Early Interventionist:_____

DSN Board/Provider:_____ Phone:_____

Address: _____

Signature: _____ Date: _____/_____/_____

Original: Provider Copy: Consumer/Legal Guardian and File

APPEALS PROCESS IS ATTACHED

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